NTIS# PB 88-240205

NATIONAL HOSPITAL PROSPECTIVE PAYMENT EVALUATION

CASE STUDY SITE REPORT:

MOBILE, ALABAMA

December 8-12, 1986

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This research was supported by Contract No. 500-85-0015 Work Assignment No. 10: Case Studies of the Impact of the PPS, from the Health Care Financing Administration. The views and opinions expressed in this report are the contractor's and no endorsement by HCFA or DHHS is intended or should be inferred.

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PREFACE

This is one of ten site reports of case studies conducted between September and December, 1986, by staff members of Abt Associates, Inc. and Health Economics Research, Inc. under Contract No. 500-85-0015 to the Health Care Financing Administration (HCFA). The views expressed are our own and no endorsement by HCFA or the Department of Health and Human Services is intended or should be inferred. Each report is a summary of the facts and subjective comments from all participants at one of the ten sites.

This report characterizes the structures of parts of the health care industry (e.g., hospitals, nursing homes, home health agencies) in this site as they were perceived by members of the study team. Individual respondents and institutions are not mentioned by name, nor are they meant to be identifiable. We are interested in generalizing about the responses of the industry to the Medicare prospective payment system, not in pointing out any one type of response. We would like to raise the appropriate policy issues objectively and from all points of view. These issues can then be addressed in the statistical analyses of data on beneficiaries and providers, which in turn will be synthesized by HCFA staff into the Congressionally-mandated report about the impacts of the prospective payment system.

The ten site reports will not make up the report to Congress. The ten sites are not a scientifically representative sample of the nation's health care providers. Therefore, they are only illustrative of what is happening across the country. As such, they have already proven to be invaluable to the study staffs. The information and subjective opinions of the 500-600 respondents will be incorporated in the analyses of secondary data in five topic areas: hospital competition, alternative health plans, medical practice patterns, post-hospital care, and program operations. They are being used in developing hypotheses, exploring unexpected results and raising policy concerns.

We once again thank those many respondents who so generously gave us their time for the discussions that provided these insights. Special thanks are also due to the support staffs of Health Economics Research and Abt Associates for arranging the site visits and producing the reports, and to the secretaries of participating executives who coordinated the interviewing schedules in the field.

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1.0 OVERVIEW OF MOBILE, ALABAMA

Mobile, Alabama, is located in the southwestern part of the state on Mobile Bay, 30 miles from the Gulf of Mexico. Shipping, the paper industry, and tourism are currently major economic activities in the area. Oil in the Gulf may have contributed to the growth of the MSA in the 1970s, but is reportedly not major enough to depress the economy in the current industry recession.

Efforts are underway to bolster Mobile's image as an attractive area for businesses to locate and grow. Community development activities focus on strengthening the local economy, which is described as "sluggish" with "some catching up to do." Economic conditions are slow but stable and the area lacks a significant base of large employers. These facts shape the local health care industry. In other sites, large employers have greatly contributed to the demands for cost containment and new insurance options. In Mobile, these pressures are far less, and the local issues differ from those observed elsewhere.

The Metropolitan Area is made up of Mobile County (1980 population, 365,000) and Baldwin County (79,000 in 1980). Both grew very rapidly between 1970 and 1980. Compared to the national ten year growth rate of 11.4 percent, Mobile County grew 15.0 percent; Baldwin County, 32.3 percent. The latter growth may have been due in part to an influx of retirees to Baldwin County where they comprise a somewhat above average percentage of the population (12.5% over age 65 versus an 11.3% U.S. average). However, this is not the major impetus; the county has been experiencing high growth rates for the last quarter century and the elderly have consistently been only somewhat more concentrated here compared to either the state or the nation as a whole.

The city of Mobile grew 5.5 percent between 1970 and 1980 (from 190,000 to 200,000) and another 2.1 percent (to 205,000) by 1982. This growth was pointed to by a number of respondents as important to an understanding of the area's health care industry, especially the hospital sector. The city is now divided roughly in half by I-65 which runs north and south between the older, historic Mobile and the growing western half, which extends past the University of Southern Alabama to the airport. Two-thirds (4 of 6) of the short-term acute-care hospitals and 81 percent of the general hospital beds have been located in the eastern half of the city. This has left the newer, more affluent western half of the city as virgin territory for health care providers. Two for-profit hospitals located here in 1975 and 1981, and one of the oldest institutions has moved here as of early 1987. One other facility is considering a move as well.

These relocations will leave two or three institutions vying for the eastern half of the hospital market and trying to control the health costs of the indigent population, which is most concentrated in the northeastern corner of the city. While there are disadvantages to being close to the poorest patients, the hospitals on the northeast side are also more accessible to the rapidly growing market in Baldwin county.

Of the thirteen hospitals in the Mobile Metropolitan Area, two are psychiatric facilities and one is a rehabilitation hospital. Six of the

ten non-Federal, short-term acute-care hospitals are located in Mobile itself and contain 88 percent of the acute-care beds currently available in the area. Of the ten, four are for-profit institutions, ranging in size from 38 to 252 beds. Of the six non-profits, one is church-affiliated, three are county-controlled, and another is the state-controlled (according to the AHA Guide) university medical center. The largest area hospital (621 beds) is an unaffiliated nonprofit. It handles over 35 percent of the admissions and almost 60 percent of the surgeries in the MSA.

PPS has had a noticeable impact on Mobile-area hospitals. From 1983 to 1985, occupancy rates fell by 10 to 20 percent. The decline can be attributed to a PRO-induced reduction in Medicare admissions, some decline in non-Medicare admissions, and a 10 to 15 percent drop in the lengths of stay for all patients.

Financially, most Mobile-area hospitals appear to be either roughly breaking even or earning moderate (5 percent or so) profits. One hospital, with an occupancy of only 30 percent, has suffered substantial losses and one respondent is concerned that it may close. Rural hospitals near Mobile have reportedly also experienced severe financial difficulties since the inception of PPS.

As a result of their financial situations, Mobile hospitals have made a major effort to reduce costs. The greatest reductions have occurred through lower staffing and increased labor productivity. More part-time work and outside-contracted services have also been used to hold down costs. More attention is paid to buying inputs at minimum cost. Interviewees feel that PPS has reduced waste and abuse in the system.

Price competition is weak. HMOs and PPOs are not yet strong enough to instigate effective price competition. Rivalry for a profitable insurer-mix is keen, however. Commercial insurers pay charges, so their enrollees are most attractive followed by Blue Cross subscribers, Medicare, and finally Medicaid patients and the indigent. The hospitals shape the insurer mix through hospital location, service mix, competition for physicians, and patient amenities.

The local market for alternative health plans is currently small but changing rapidly, as was widely evident during the site visit. Of the three HMOs, which had all become operational since PPS, one had closed its Mobile offices six weeks before the visit and a second was acquired by a competing national chain during the week of the case study. Mobile's provider community is already reportedly grumbling over the uncertainty this acquisition introduces. The previous management had already been trying to control costs by channeling patients to the less expensive hospitals and the acquiring corporation is described as "more aggressive." Word has it that at least one hospital board may be worried that the new HMO owners will exclude that hospital in future because the board did not cooperate with the previous management (admitting HMO patients on a full-charge basis only).

Only one of Mobile's HMOs has been serving Medicare beneficiaries and this program has been offered only since last August. The plan offering this program is the oldest HMO in Mobile (by a few months) and

is affiliated with the university medical school faculty and hospital. It contracts exclusively with the university medical centers which sponsor a full range of services through their own network. The Medicare plan operates as a supplement program on a cost basis and is considered "an early learning experience" by administrators. The program is considered too new to assess properly. Risk contracting has never been considered seriously because "we only hear nightmares about risk-based Medicare contracts."

Mobile physicians are indeed changing their patterns of medical practice, but most assert that the greatest impetus to that change is the PRO, and the fact that private payers are beginning to emulate the PRO activities. Several insurance companies now require the same type of preadmission approval formely used by the PRO. Non-PRO-related pressure on physicians by hospitals feeling the pinch of PPS appears to be relatively small, possibly because of competition among hospitals.

Several doctors express the sentiment that the quality of care for Medicare patients has been degraded by the institution of PPS. Many feel strongly that social conditions as well as medical conditions should be considered. One doctor says that Medicare no longer allows him to operate with "compassion."

One illuminating set of statistics shows what appears to be the doctors' natural reticence to admit Medicare patients. Most doctors report that their Medicare percentage of office practice is larger than their Medicare percentage of hospital admissions, primarily because of the burdensome requirements of admission. One doctor says he now does IV antibiotic, aerosol, and other complicated treatments in his office for that reason.

Finally, there appears to be a general perception among Mobile doctors that the combination of PPS and PRO is a "back door" attempt to reduce the extent of Medicare benefits. There is a general belief that HCFA should be more forthright about what is happening, but doctors are ambivalent about the goal itself. This is summarized by one doctor who says, "It's nice to have a Cadillac if you can afford one, but it's important to decide how much of the GNP is going into health care."

The post-hospital industry in Mobile reports typical impacts of PPS on patient care--earlier and sicker discharges, increased complexity of services provided in the home and in nursing homes, and improved discharge planning at the hospital. Nursing home beds and home health care agencies are in adequate supply, presenting no real supply shortages. As in other sites, some reported placement problems are related to patient status (ability to pay or service needs), not availability of resources. Similarly, there are reports of economic transfer and discontinuation of services due to payment status.

Nursing home administrators think PPS has had some positive effects on their operations. Tighter payments and definitions have made homes more efficiently managed. Increased acuity has forced homes to increase the skill levels of their staff, which increases their costs but encourages them to provide a wider range of services. However, homes continue to complain about the inadequacy of the rates, and the lack of

coverage for services to chronically ill patients. In the future, some providers will move into the high tech business by providing sub-acute care to hospital's outlier patients.

Mobile is distinguished from other sites in two ways. First, the Blue Cross proposed Competitive Medical Plan (CMP) has most providers very angry and anxious about the capitated rates for home care services and durable medical equipment (DME). In addition to the perception that the rates are woefully inadequate, home care providers are concerned about hospital entry into "their" business. Second, every home care provider interviewed mentions the problem of fraud and abuse in the home care and DME business. Blue Cross also raises this issue and its efforts to combat excessive (unnecessary) service provision.

Compared to some other case study sites, there is a noticeable lack of positive comments about PPS. There are some acknowledgments that PPS has provided impetus to reduce waste in the industry but some respondents think this is overstated. Mobile-area hospital administrators voice a number of general and specific criticisms of PPS. Several feel that Medicare reimbursement policies are leading to a "two-tiered" medical delivery system in which Medicare beneficiaries will receive a lower quality of care. Some administrators think that the closing of rural/suburban hospitals will raise costs as well as reduce access to services. Other comments center on the PRO, outlier and capital payments, the update factor and physician incentives.

2.0 SCOPE OF INTERVIEWS

Of the ten non-Federal, short-term, acute-care hospitals in this site, six participated in the case study. These included four of the six general medical/surgical hospitals in Mobile, a small hospital in the northern Mobile suburbs, and one of the three Baldwin County hospitals.

Sixty people were interviewed over a five day period. Table 1 presents the number of interviews by topic area and the positions of the respondents. Twelve interviews focused on hospital competition; 6, on HMO activity; 14 were concerned primarily with utilization of resources and patient management in the hospitals; 15 were conducted in the post-hospital health care industry; while 13 were with those involved in program operations.

To gain insights into the competitive environment of the Mobile hospitals, six chief executive officers were interviewed about their strategies and the relative positions of their hospitals. Information relating to price competition and financial standing was obtained in interviews with four chief financial officers plus one specialist in Medicare reimbursement issues. Additional insights were gained from an administrative assistant responsible for a variety of operations pertinent to PPS.

Concerning HMO activity in the area, six highly diverse interviews were conducted. One with a Chamber of Commerce representative provided considerable background information. A representative of the plan that had recently withdrawn from the Mobile market was interviewed by telephone. Interviews at the other two plans were conducted with a chief financial officer, a medical director, a utilization reviewer and a hospital contract administrator.

In the area of utilization and patient management, members of the site team spoke with six utilization reviewers, six chiefs of staff, and two other physicians with admitting privileges at one or more of the hospitals visited by the site team.

In the aftercare industry, team members interviewed eight hospital discharge planners, administrators of five nursing homes and five home health agencies, and an administrator of the visiting nurse association. Concerning program operations, interviews included the director and six other administrators of the Peer Review Organization and six representatives of the fiscal intermediary.

TABLE 1

MOBILE, ALABAMA, SITE VISIT INTERVIEWS BY TOPIC AREA

	Hospital Competition	HMOs	Utilization and Patient Management	Aftercare Industry	Program Operations
CEOs	6				
CFOs/Medicare Reimbursement Specialists	5				
Other administrators	1				
HMO Representatives		5			
U/R Coordinators			6		
Chiefs of Staff			6		
Other Physicians			2		
Discharge Planners				7	
PRO Administrators					7
Fiscal Intermediary					6
Nursing Home Administrators				3	
Home Health Agency Administrators				5	
Chamber of Commerce Representative		1			
Total Number of Interviews	12	6	14	15	13

3.0 HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS

3.1 Competitive Market Structure

The Mobile hospital industry is an oligopoly that is experiencing a marked increase in competition. The area is dominated by four hospitals that are currently located in the geographic center. The largest of these (in terms of market share) is roughly twice the size of its next largest rival. The third and fourth are roughly equal in size and together comprise about 30 percent of the market.

These rivals exhibit a large degree of mutual interdependence. That is, each of these institutions is too large to be ignored by its competitors. If one changes a policy, it will noticeably affect the markets of the other hospitals. In the past, each hospital had a special niche. One had a teaching mission, another saw itself as the leader in innovations, each smaller hospital had a geographic monopoly, and so on. Now, the status quo is changing and institutions are jockeying for position.

In vying for market share, one tertiary hospital has formed some formal and informal links to outlying community hospitals to feed more complicated cases to the Mobile facility. The outlying institutions are on both the eastern and western edges of the market. A second tertiary facility has vertically integrated part of its market by helping to form a health maintenance organization that contracts exclusively with its medical service network.

Another form of integration is occurring with respect to home health agencies. Some hospitals have purchased or are trying to purchase existing agencies. This is in response to new contracts with Blue Cross of Alabama that require hospitals to provide post-hospital care and durable medical equipment to Medicare enrollees not covered by SSI for $400 per capita. Although the payment is generally viewed as inadequate, the hospitals were caught in a classic dilemma: signing may indeed lead to short-term losses on the services but not signing is likely to lead to longer term losses of market share. One strategy to minimize expected losses is to own a home health agency and, as a consequence of the sudden demand, the prices of agencies have reportedly risen to the range of $100,000 to $200,000.

Most of the hospitals in this site report fairly low levels of Medicaid and charity cases or bad debt. Admissions of the indigent appear to be largely concentrated at the university medical center which receives some reimbursement from the Mobile County government for indigent care. (State money to this institution is only for medical education costs and other counties do not contribute funds although their indigent are cared for in Mobile.) A second hospital also admits a significant number of Medicaid recipients and the indigent, reportedly because of its location and emergency department.

3.2 Hospital Performance

PPS has had a noticeable impact on Mobile-area hospitals. From 1983 to 1985, occupancy rates at Mobile hospitals fell by 10-20 percent.

While the average city-wide occupancy rate was roughly 75-80 percent in 1983, it is only 60-65 percent today. The decline in occupancy can be attributed to a PRO-induced reduction in Medicare admissions, some decline in non-Medicare admissions, and a 10-15 percent drop in the lengths-of-stay for all patients. Occupancy rates in 1986 are similar to those of 1985, or slightly higher.

Financially, most Mobile-area hospitals appear to be either roughly breaking even or earning moderate profits. Total margins range from a loss of a few percent to a profit of up to 5 percent or more. Because of the reduction in Medicare admissions (approximately a third of total volume in the area) and, in some cases at least, a hospital-specific portion which exceeds the PPS federal rate, the profitability of most Mobile hospitals has deteriorated somewhat in the last few years. However, the only participating hospital in serious financial trouble is a small community hospital that has an occupancy of only 30 percent. This facility has suffered substantial losses in the last few years and reportedly may close in the future. One interviewee reports that rural hospitals near Mobile have also experienced low occupancies and severe financial difficulties since the inception of PPS.

A few hospitals do not conform to the trend of declining profitability. One community hospital in southwestern Mobile has just turned profitable in the last few years as it has become established in its community. Another hospital's margin would have increased this year if not for an extraordinary one-time expense due to the refinancing of a bond issue.

3.3 Changes in Hospitals Conduct Over the Last Five Years

The term conduct denotes behavior and strategy on the part of firms in the market. The mutual interdependence of the Mobile hospitals industry, discussed in Section 3.1, is an example of how firms' conduct affects their competitive positions. Other examples are changes that lower costs, changing prices, and forms of non-price rivalry, such as advertising. Lowering costs will increase profits or lower losses even if market shares do not change. Price reductions and non-price rivalry are both ways in which firms compete for market share.

3.3.1 Lowering Costs

As a result of their relatively less favorable financial situation recently and the incentives of prospective payment, Mobile hospitals have made a major effort to reduce costs. Hospital administrators think that PPS has led to greater efficiency and productivity in hospital operations. Not surprisingly (due to lower admissions and lengths-of-stay), the greatest cost reductions have occurred through lower staffing and increased labor productivity. FTEs have been reduced, job descriptions expanded, and employees have been used more flexibly. For example, one hospital has trimmed its FTEs by 15 percent over the last two years; another by 30 percent from 1983 to 1986. More part-time work and outside-contracted services have been used to hold down costs.

Wage increases have been held to the rate of inflation. Two-tiered wage scales in which new employees are hired at lower wage levels have been introduced. One respondent remarks that nonprofit hospitals no longer share the excess of revenues over costs with employees.

More attention is now paid to buying inputs at minimum cost. One hospital now solicits three bids for purchase contracts instead of one. Several hospitals have entered into cooperative agreements to buy in bulk at discount but most already belonged to purchasing groups. Management perquisites have also been trimmed to save money. Travel, entertainment, and magazine subscriptions are down. Interviewees feel that PPS has reduced waste and abuse in the system.

3.3.2 Price Competition

Price competition among hospitals in the Mobile area is weak. Although hospital managements do pay some attention to other hospitals' prices in setting charges, prices quoted to HMOs for the same procedure appear to vary widely among Mobile hospitals, indicating that competition is not vigorous enough to force them to converge. HMOs and PPOs are not strong enough to instigate effective price competition. This business constitutes a small fraction of hospitals' volumes. Moreover, a few alternative health plans are not independent organizations which play off one hospital against another for a better price. The largest in the city was founded (at least jointly) by a hospital.

While not much of a factor at this time, Mobile hospital managements expect that HMO/PPOs will be a source of increasing price competition in the near future as their enrollments and aggressiveness rise. As in other areas of the country, outpatient/ER business in Mobile is the most price competitive. The presence of a large number of free-standing ambulatory clinics in the Mobile area is important in promoting competition in these lines of business.

3.3.3 Non-Price Competition

In the Mobile area, the emphasis in hospital competition for market share is not on attracting volume *per se*, but on obtaining the right kind of patients. Rivalry for a profitable insurer-mix of patients is keen. Commercial insurers pay charges, so their enrollees are the most attractive. The Blue Cross per diem generally pays 80 to 90 percent of charges, making Blue Cross subscribers second most attractive. The small number of HMO/PPO subscribers (about 5 percent of the total market) fall into this second tier of desirability. Medicare patients are ranked next, with a typical discount from charges of 35 percent. Medicaid patients occupy the next level of desirability, with non-Medicaid indigents the least attractive of all.

Mobile hospitals attribute their "bottom-line" to commercial/Blue Cross patients. Medicare payments cover the incremental costs of treating beneficiaries plus making some contribution to overhead. Medicare patients are therefore accepted as a means of "spreading fixed costs," although an exclusively Medicare patient-mix is not desired by

Mobile hospitals. Medicaid/indigent patients are avoided except, perhaps, by the university medical center, which is the provider of last resort and receives some subsidies to treat them.

Mobile hospitals have shaped the insurer mix of their patients in several ways. One of the most important, albeit long-run, methods is through location. The hospital industry is following the migration of population and wealth to the west, where the proportion of charge-paying patients is higher, and that of indigent patients, lower. Two proprietary hospitals have opened in the western part of the city. The larger of these was founded by a doctor in 1975, and is located just to the west of the north-south interstate near the center of the city. The smaller hospital, founded in 1981, is in the far southwestern part of Mobile and is the second HCA hospital in the city. One more hospital has just fled the traditional hospital cluster, relocating on the far western edge of Mobile.

This locational competition, to attract profitable patients by locating near them, or to avoid money-losing indigent patients by moving away from them, is an important element of the long-run competitive process in the Mobile area. However, the shift of hospital resources raises serious questions about the provision of indigent care. The burden of indigent care may fall even more heavily on the hospitals remaining in the eastern part of the city, especially the university medical center. The medical center's current bad debt is approximately 40 percent of expenses. Whether it can survive with this level of uncompensated care is a concern. As a competitive response, the medical center is considering moving a major part of its capacity to the university campus in the western part of the city to serve residents there. The trauma and women and children's units, used heavily by indigents, would reportedly remain in the current location.

As in other areas of the country, service mix is a second element of competition among Mobile hospitals. In Mobile, the mix of services is sometimes chosen to avoid certain patients, rather than attract them, thereby achieving a more remunerative mix of patients. Specifically, several area hospitals do not have staffed emergency rooms. Since the ER is a principal hospital access point for Medicaid/indigent patients, the lack of ER facilities substantially reduces the volume of such patients.

One suburban hospital has closed its ER to lower its volume of indigent patients. The precarious financial situation of the hospital forced this move, because the ER was a big money loser. The elimination of this ER may represent a serious service reduction to the surrounding community. The hospital is the only one in the area; emergency patients must now travel more than 10 miles to another facility. Ironically, this hospital has found its elimination of the ER to be a two-edged sword. Physicians are now reluctant to admit there because around-the-clock emergency services are not available to their patients.

Area hospitals with ERs incur higher proportions of self-pay/bad debt. The university medical center is the prime example. The two west Mobile proprietary hospitals have ERs and are located near major highways that provide easy access. Consequently, their proportion of bad debt is 5-10 percent, although their location in wealthier areas of the city limits their burden of indigent cases.

In other services, several hospitals seem to vie for leadership. One tertiary care facility provides the area's trauma center, burn unit and neonatal ICU, all of which traditionally must be subsidized because of their high costs. Two hospitals have strong cardiac surgery programs.

In addition, one hospital has a very strong commitment to high technology medicine, with facilities which in some cases rival those of the larger area institutions. For example, it is the only area hospital with a lithotriptor and also has MRI and is committed to installing any major new technologies which appear on the scene. The high technology orientation is one means this relatively new hospital uses to draw patients away from the more well-established Mobile institutions. It has aggressively expanded in the last 10 years, growing to seven times its original size.

Declining occupancies and inpatient/outpatient substitution due to PPS have caused reconfiguration of hospital services. For example, one hospital has converted nursing stations into a rehab unit, a psychiatric unit, and (possibly) a diabetes unit and sleep laboratory. Another hospital has expanded its ancilliary, radiology, emergency room, and outpatient services, and added four outpatient surgery suites and an outpatient diagnostic center. In addition, alcohol, diabetes, and rehab services have been augmented. A third hospital emphasizes special product lines including cancer and cardiology/pulmonary.

Competition for physicians is a third important means of attracting patients. Physicians appear to have been in a strong position vis-a-vis hospitals in Mobile. They enjoyed community-wide, open admitting privileges. Thus, doctors were able to "dump" undesirable patients (e.g., Medicaid enrollees and the indigent) on a hospital, or, conversely, direct profitable patients to one. Even without collusion among physicians, the open admitting privileges lead to a strong bargaining position for physicians. Moreover, three proprietary hospitals in the area were founded by doctors and maintain a strong physician orientation. A manifestation of physicians' power may be the relatively lenient treatment (compared to some areas of the country) by hospitals attempting to change practice styles in response to new reimbursement incentives.

A number of hospital characteristics influence physicians' choice of where to admit among the community-wide alternatives. Intensive and personalized nursing care, which several hospitals emphasize, is important to physicians. So is a full range of services and emergency facilities. Geography is often a deciding factor in physicians' choice of hospital. Many doctors have joined the population, wealth, and hospital shift to west Mobile; the new hospitals located in that section of the city have an advantage in recruiting these physicians. Mobile hospitals have also employed direct financial incentives to lure doctors. Free office space or rent is a common device. The hospital that has just relocated in the western section of Mobile has been particularly aggressive in recruiting physicians recently.

While competition for doctors is vigorous in Mobile, it is also selective. Post-PPS, hospital administrators pay more attention to a physician's mix of patients when recruiting. Doctors who treat a high

proportion of commercially-insured patients are the most desirable. At least one hospital management also avoids recruiting physicians who would admit Medicare patients in DRGs on which the hospital loses money. Specifically, this hospital avoids orthopedists and ophthalmologists because management knows from its monthly DRG payment/charges reports that it loses money on hip treatments and cataract removals.

Although recruiting physicians is regarded as much more important, directly appealing to patients through advertising or amenities is an element of the competitive process in the Mobile area. Promotion consists of general image-building by hospitals or advertising of specific, profitable services. Television advertising is new to the area and is generally of the image-building variety. One hospital is buying cable TV time to target its advertising more precisely. It is also sending a newsletter to every address in its catchment area. Other hospitals are using newspaper advertising to promote specific services, especially outpatient surgery, a heart center, a cancer center, or new services such as MRI, lithrotripsy, and obstetrics/gynecology units. The obstetrics business is regarded as especially important because of the likelihood of followup visits by women who have their children in the hospital, so it is heavily promoted.

Patient amenities is a competitive strategy pursued by some Mobile hospitals. Personalized nursing care, together with physically attractive facilities, are major elements of amenities. The for-profit hospitals seem to emphasize amenities and have a high proportion of private and semi-private rooms. Some interviewees suggest that the level of amenities (e.g., room with a lake view) might vary with the insurer-status of patient, but that financial remuneration would not play a role in level of medical care rendered.

3.4 Reactions to PPS

Accounting information by DRG has been used in responding to PPS. Some Mobile hospital administrators see reports of charges or "costs" (discounted charges) compared to payments by DRG and sometimes by physician. Hospital lengths of stay compared to the national average LOS by DRG are often also shown. In at least one hospital, charges are broken down by department. "Contribution margins" by department indicate which are most profitable.

Cost accounting systems are in their infancy in Mobile-area hospitals; as in most areas of the county. Most hospitals use informal methods to allocate overhead to different departments and to estimate the true, economic cost of providing services. The use of DRG charge/payment information varies. Some administrators pay little attention to it. Others initiate studies to discover why some cases cost more than others or what is the reason for cost outliers. One hospital identifies financial winners and losers by disease group and uses this information in recruiting physicians.

Compared to some other case study sites, there is a noticeable lack of positive comments about PPS. There are some acknowledgments that PPS has provided impetus to reduce waste in the industry but some respondents think this is overstated.

Mobile-area hospital administrators voice a number of general and specific criticisms of PPS. Several feel that Medicare reimbursement policies are leading to a "two-tiered" medical delivery system in which Medicare beneficiaries will receive a lower quality of care than enrollees of commercial or Blue Cross insurance plans. Different levels of care will evolve because of Medicare's lower reimbursement rates, especially if the PPS update factors continue to fall short of the rate of increase in other insurers' payments. In the extreme, respondents suggest that hospitals might refuse Medicare patients.

The quality of and access to care are mentioned as particular areas of concern. Reduced services (e.g., the closing of emergency rooms) to both Medicare and non-Medicare patients as a result of tightening reimbursement policy is said to be occurring. Of special note are the financial difficulties and possible closings of isolated hospitals in rural or suburban areas. If these hospitals close, the burden on the elderly to attain access to hospital services would be greatly increased. Moreover, in emergencies, the lack of nearby hospital facilities represents a serious reduction in access to medical services.

Some administrators think that the closing of rural/suburban hospitals will raise costs as well as reduce access to services. They note that rural/suburban hospitals treat patients more cheaply than the large urban hospitals. However, with the smaller hospitals closing or being transformed into "feeder" centers for the big hospitals, a larger proportion of patients will be treated at higher cost in large urban hospitals in the future.

Administrators have several complaints about PRO review. One interviewee feels, that in some cases, PRO admission criteria are imposing an unwarranted travel burden on patients. If a patient has traveled a long way to a hospital for testing, it makes more sense for that patient (especially when elderly) to stay overnight in an observation bed, rather than having to return home, then repeat the journey to the hospital the next day. Yet this type of admission would be denied by the PRO. Also, it is felt that it is better for the patient and cheaper if patients are admitted and treated at an early stage of development of their morbidity. The PRO, however, denies admission until the condition has progressed to a severe state, at which time it is much more difficult and costly to treat. One respondent exclaimed: "You can't admit a patient to the hospital until he is dead!"

It is further noted that it is cheaper and more effective to treat newly-discovered comorbidities at the time of the original admission. However, as PPS is currently configured, the hospital would have to discharge the patient, then readmit after the comorbidity has worsened to be reimbursed for treating it. Hospital personnel think that physicians are forced to order unnecessary tests to document diagnoses for PRO review. Some also feel that preadmission screening, which ended in the summer of 1986, was more equitable to hospitals than the current retrospective denial system. With the former modus operandi, a hospital administrator knew at least whether it would be paid for treatment prior to rendering it. One interviewee questions the need for direct PRO regulation of admissions. He suggests that financial incentives could be

used instead. Medicare should simply pay the outpatient rate where appropriate and let the hospital be at risk financially for admitting a patient to the inpatient unit.

Outlier payments are the cause of a complaint of the administrators of at least one small hospital. This hospital was "killed" financially by large cost outliers and PPS outlier payments are reportedly not sufficient to rectify the situation. As a small facility, this hospital is subject to considerable risk through large outliers, because it does not have as many cases over which to average costs as a large hospital does.

Prospective payment for capital worries hospital administrators. Most think it will adversely affect them. Several hospitals that are either new or have recently completed major renovations feel especially vulnerable because of their high depreciation and interest charges. Administrators think old capital should be grandfathered into any new system.

Managers feel that the PPS update factor is inadequate, that payments should not be ratcheted-down. They also think that the system is tinkered with too much, that it is difficult to plan under PPS. Finally, they believe that physician incentives should be brought into line with those of hospitals.

4.0 PPS AND ALTERNATIVE HEALTH PLANS

4.1 The Structure of the Industry

Alternative health plans (AHPs) are a recent addition to Mobile's health care market, and play a small and limited role as providers or payers of health services. Prepaid health care was first introduced to the area in 1984 by the university medical center, which established a non-profit staff model HMO to gain experience with what appeared to be an inevitable national trend in health services delivery. Since then, two additional HMOs have entered the market: an IPA sponsored by a national for-profit chain, and a plan developed as a network by a national proprietary hospital chain.

Plans seeking to enter the market and develop services in Mobile have encountered several difficulties. Economic conditions are slow but stable. The area also lacks a strong base of large employers. Community development activities are focused on strengthening the local economy, which is described as "sluggish," with "some catching up to do." Other factors that have contributed to plan difficulties, especially at start-up, include the relatively conservative attitudes of providers, consumers inexperienced with alternative delivery systems, and a hospital sector that has only recently begun to experience the competitive pressures of declining occupancy.

The local market for AHPs is changing rapidly, despite these obstacles. None of the plans was operational prior to the PPS. Although the program may be partially credited with introducing and reinforcing many of the conditions leading to AHP startup, these conditions have occurred primarily as indirect effects of hospital competition, as yet not fully developed. Like Mobile's hospital sector, the AHP market is in transition, forging an identity and seeking a niche as competition restructures the local health care delivery environment.

During the site visit to Mobile the new, changing nature of the AHP market was widely evident. One of the three HMOs, six weeks earlier, had closed its Mobile offices -- less than a year after entering the local market. A plan representative who was contacted in another part of the state reported that Mobile was a difficult market for the plan, and had not been profitable for HMO activity. However, the decision to leave the area was the result of a decision by the parent corporation, a major hospital chain, to discontinue HMO options in all areas where the firm does not own hospitals. Relying on networking and contracting arrangements without the control of ownership, these plans had proved too costly to operate.

Mobile's other nationally sponsored plan was also undergoing major changes at the time of the visit. Within days of the team's arrival, the plan had been acquired, with its national affiliates, through a takeover by a competing HMO chain. Top plan administrators, only days earlier, had emptied their offices. Staff who remained at the plan agreed to interviews, to discuss the HMO as it had operated in the area prior to the takeover. How operations and administrative practices would be changed as the new owners began restructuring was not clear, with the exception of the few changes announced with the acquisition.

For this case report, interviews were conducted at each of Mobile's two HMOs: a non-profit, staff model affiliated with the university medical center and the newly acquired for-profit IPA sponsored by a major national chain. The university-affiliated plan is Alabama's only federally qualified HMO. Both plans have been in operation for less than two years, and entered the market within months of each other.

4.2 Contracting for Hospital Services

Mobile's HMOs represent two extremes of organization and sponsorship, which dictate the possibilities for each plan to contract with hospitals, physicians, and other providers for service delivery arrangements. The staff model was established by the university medical center and contracts exclusively with its facilities and staff. Respondents were reluctant to discuss the particulars of these arrangements; however, the university medical centers sponsors a full range of provider services, all of which are provided through its own network.

The competing plan contracts with most of the remaining local hospitals, and has arranged for use of all emergency room services in the area. Per diems and discounted charges are negotiated with most hospitals, although arranging such contracts has required considerable effort on the part of plan executives to educate hospitals to the HMO concept. Three hospitals in particular have been "reluctant to cooperate" with the prepaid health plan, including one of Mobile's largest facilities. These hospitals have agreed to admit the HMO patients on a full charge basis only. Because contracts with local hospitals vary greatly, with significant cost differences to the HMO, a concerted effort has been made to try to "divert patients from expensive, fee-for-service facilities."

Other pressures are also helping to bring acceptance of prepaid health care to Mobile hospitals. Mobile's provider community is already reportedly grumbling over the uncertainty of changes to come. For example, word has it that one hospital board has already expressed regret at not having cooperated sooner with the plan, for fear of being excluded from potential negotiations with new owners. "Hospitals are beginning to see the writing on the wall," one respondent explained. "Now some of the hospitals that had been uncooperative previously are seeing that they will be left behind...they regret that they weren't more agreeable before."

The movement of one of Mobile's largest hospitals from the downtown core to a complex offering a full range of physician and hospital services at the outskirts of town has provided significant impetus for hospitals to consider networking with physician groups and to seek PPO-type contracts. The perceived threat to facilities competing for market share has also generated a new willingness for other hospitals to consider more favorable arrangements with Mobile's IPA model.

Another, more recent, encouragement to cooperation is posed by changes that are anticipated as a result of the recent acquisition of this HMO by a reportedly "more aggressive" national chain. Under the

previous administration, the plan, although also owned by a national chain, had been administered through networks of solo practitioners and groups established locally. Contracts were established with hospitals based on their affiliation with admitting physicians. Restructuring under new ownership, however, is likely to alter these arrangements. While it is not clear what direction the reorganization will take, the incumbents are known to structure plans more uniformly across locations, maintaining contracts with smaller numbers of cost efficient hospitals and physicians. The new plan is also perceived by many to use more stringent utilization review with greater control over provider practices and patterns of treatment.

4.3 Physician Contracting

Like HMO arrangements for hospital services, contracts with local physicians reflect the significant differences in each plan's model type. Mobile's staff model HMO uses physicians affiliated with its medical center sponsor. Physicians provide services at two centers. Members can access a full range of services including specialty services or referral at either location. A team concept, revolving around a primary care physician "gatekeeper," is used to coordinate services of medical and nursing specialists, technologists and other auxilliary health personnel. Physicians new to the HMO receive training provided by the plan.

Mobile's IPA model, by contrast, arranges services through a primary care network centered around private, primary care physicians in Mobile and Baldwin counties who are willing to allocate a percentage of their practice to treat plan members. Individual practitioners and physician groups are recruited "by word of mouth" in the community. Referrals for new affiliates often come from physicians themselves, who may recommend their peers as "the sort of physician who would practice well under prepaid arrangements."

Under contract to the plan, participating physicians are responsible for providing primary care services in addition to coordinating the provision of outpatient ancillary services and specialty services from referral physicians. For these services, each primary care physician receives the same capitation payment which is expected to cover all patient care costs, including specialty care and hospitalization.

The plan has established risk pools for specialty care and hospitalization, with stop-loss arrangements per patient included from these pools to reduce individual physician risk. One hundred percent of surplus funds from the specialist pool and 75 percent of surpluses from the hospitalization pool revert to each participating physician. The incentives of plan capitation subject to these risk arrangements have reportedly increased physician awareness of the full costs of patient treatment, resulting in more selective referral to cost efficient specialists and hospitals. One plan representative adds that participating physicians have informally approached their peers participating in specialties when the referring physician considered specialty fee structures excessive. In some cases this has resulted in

lower charges. Where specialists have not been responsive to this peer pressure, subsequent referrals have often been directed to less costly providers.

4.4 Marketing and Benefit Availability

Mobile's HMOs have eased their way into the community with little overt competition among plans. Benefit offerings are similar at each plan, but are provided with different restrictions on provider access, determined by the staff model or IPA structure used by each respective plan to organize services. Both HMOs have also targeted different markets in their early development, again reflecting their different missions. The staff model plan met with a ready membership base through the university medical center. In fact, the plan was created originally to serve medical center employees although they now comprise a minority of enrollees. Efforts are now underway to expand the plan's market to include more employer groups in the area, and to continue enrollment of Medicare beneficiaries under a recently implemented cost contract. The reputation of the university, its facilities and staff, and the "local" roots of the plan are major attractions to group enrollment.

Marketing activities have been more difficult for competing plans. Both of these national plans, one shortlived and the other the recently acquired IPA, experienced slow growth initially, directing considerable effort to educate both providers and consumers to prepaid health care. The lack of large employers in the area has also impeded enrollment potential, a problem now facing the university staff model.

The practical matter of marketing has been a vast learning experience for the remaining nationally affiliated plan. Respondents comment that early marketing approaches may have been detrimental to the acceptance of "HMO-style health care" and start-up attempts at group enrollment. Plan executives quickly learned that "New York marketing styles just don't work in a conservative, close-knit community like Mobile." Subsequent changes "in style and approach" have been necessary, meeting with greater success -- although some problems related to the plan's image in the community remain.

Not surprisingly, each of the plans currently operational in Mobile identify Blue Cross and other indemnity plans as their major competitors. Both plans stress the comprehensive services, limited out-of-pocket expense, and the lack of claims forms and paperwork typical of health care delivery through HMOs as their "leading edge" over fee-for-service options.

An important feature of competition in the market for HMO membership is the impact of federal qualification status on a plan's ability to provide benefits at premiums competitive with other, non-qualified plans, and indemnity options. Mobile's staff model is currently the only federally qualified HMO in the state of Alabama. Under conditions of federal qualification, community rating is required. This status has conferred the advantage that companies with more than 25 employers must offer federally qualified plans located in their service areas. Federal qualification also has its downside, however, especially

in markets where insurance options rated to employer group experience are significant competitors. As a plan executive at this HMO remarked, "Federal qualification puts us at a real disadvantage. We can't adjust rates by age and sex, like the experience-rated plans. It's hard when you are a community-rated plan facing wide-open competition."

4.5 Utilization Review

Utilization review at both plans has been the responsibility of medical professionals. UR is said to play an important role in assisting physicians with and educating them to patient care management under capitation, as well as providing monitoring and control of utilization and physician practices for the plan. The review process has taken on particular significance in the area of quality assurance, given reports that the area ranks as the third highest in the nation for rates of medical litigation.

External review criteria are used by one of the plans, which contracts with an outside organization for examination of all inpatient charts. A team of physicians, unaffiliated with the plan, performs the reviews. In-plan utilization is also routinely compared with national and state averages.

Mobile's other HMO recently hired a medical director to oversee nursing reviews performed for the plan. Formal criteria have not been used. However, staff have been notified that, as new management assumes control of the plan's administrative processes, external standards will be applied, similar to those now used by the Blues in Alabama. Utilization review is also expected to shift from a physician-directed program to oversight by a lay administrator. What the role of the HMO's medical director, a local physician, is likely to be in this reorganization remains unclear and unsettling to staff who have welcomed the addition of medical authority under the existing system.

4.6 Medicare Enrollment and Contracting

Only one of Mobile's HMOs serves Medicare beneficiaries. The Medicare plan operates as a supplement program on a cost basis, and is considered "an early learning experience" by administrators. Risk contracting has never received serious consideration -- "we only hear nightmares about risk-based Medicare contracts."

Staff feel that the program, which has been offered since August, is still too new to properly assess its performance with senior members, although interest in this option has been growing among Medicare beneficiaries in the area. Executives intend to move cautiously with enrollment, until sufficient experience has been gained serving senior groups.

5.0 MEDICAL PRACTICE PATTERNS UNDER PPS

Medical practice in Mobile in general appears to give physicians a great deal of latitude. Hospitals are geographically concentrated and tend to have a very open style of admitting privileges, so very few doctors admit to only one hospital. While this may change in the near future, it means that doctors currently have numerous alternatives for hospital care. In addition, hospital staff seem to take a fairly deferential attitude toward physicians. UR coordinators, who in many other sites have an adversarial relationship with physicians, here seem to sympathize with and defend the practices of local physicians.

Balancing this freedom is a practice pattern among physicians that appears to have been relatively frugal. Hospital medical directors claim to have had few problems in the past with physician excesses. Given this scenario, it is perhaps not surprising that PPS and the PRO especially are viewed with distaste by the local medical community. Nevertheless, medical practice patterns have been changing in Mobile, and many of the changes can be attributed to efforts of the hospitals or of the PRO.

5.1 Trends in Practice Patterns

Perhaps the most often mentioned practice pattern change is decreasing social admissions. Mobile doctors are following national trends in the reduction of medically unnecessary admissions, due to pressure from both the hospitals and the PRO. Several doctors also mention technological changes that now make many procedures available on an outpatient basis and contribute to the decline in admissions.

The length of hospital stay also has been falling, due, at least in part, to an acceptance by area doctors to recuperation periods outside of the hospital. With one exception, physicians have few complaints about the increased use of SNFs or HHAs for post-hospital care. They generally feel that the care received in these institutions is adequate, and that this particular change in practice patterns is not endangering the quality of care.

There seems to be a clear trend in some areas toward the use of specialized aftercare facilities for recuperation periods, including strokes and fractured or replaced hips. One doctor speaks highly of two such facilities, but a second doctor thinks they provide a great deal of unnecessary care solely for the purpose of remuneration.

Although HMO activity in the area is small, it appears to have had a significant impact on physician practice patterns. This may have occurred because one of the larger HMOs has an open panel form of organization in which it uses area doctors for primary care rather than having doctors on staff. In addition, no more than 10 to 20 percent of any one physician's practice may be enrollees of this HMO. This puts the HMO in contact with a large number of area physicians.

This particular HMO operates by having physicians capitated on a per member per month basis, with specialist and hospital care paid by the HMO. However, there are incentive pools for all doctors, to discourage referrals and inpatient care. In addition, they have terminated a

contract with one local doctor for performance reasons. It seems likely that participating physicians might adopt some of the HMO practice patterns for all their patients.

5.2 Hospital Strategies on Practice Patterns

5.2.1 Preadmission Screening

Most of the hospitals in the area engage in some sort of preadmission screening program. Several hospitals have established their own internal screening committees, but some have a contract with an outside panel, including the Alabama Hospital Association and the former PSRO for the area. This seems to have aroused considerable antagonism within the physician community. Several complain of being "dictated to over the phone" by persons not familiar with the case.

It would appear that the primary reason hospitals are doing this screening is to anticipate the decisions of the PRO. Some of the screening selection criteria are said to be similar to the focus of PRO reviews. There is an indication that hospitals want to avoid more intensive admission review by the PRO, if possible.

Many doctors argue that this system has become too inflexible. Often, the physicians argue, an MD will want to admit someone because they are unsure of the proper diagnosis. But these admissions, though perhaps warranted, are extremely difficult to get through preadmission screening. One doctor contends that an MD may have an admitting "opinion" but not a diagnosis. At least one UR coordinator agrees that doctors should be able to admit patients at an earlier stage of illness.

5.2.2 Utilization Review

Utilization review activities by hospitals have become a very serious activity in Mobile. UR committees and UR coordinators take an active role in many area hospitals, and doctors are keenly aware of their existence. For doctors, their presence means a great deal of pressure to make sure their documentation is in order. One doctor, who admits to several hospitals, complains about pressures to have his patients' charts completed by 3 p.m. each day. One medical director actually refused privileges to an MD until his records were complete.

In fact, increasing paperwork was one of the physicians' major complaints with hospitals. One medical staff president remarks that "I don't think the doctors are practicing any differently than three years ago. We're not wasteful and have never been wasteful. They're killing us in terms of time. You have to stop and justify everything and that takes time. The PRO isn't as bad as the insurance companies." Hospital UR coordinators express both sympathy and frustration at physician paperwork complaints. They feel that the increased documentation is vital to the hospital, particularly the attestation sheets required for each Medicare patient.

Doctors tell of little pressure to alter use of ancillary services, although UR coordinators say they monitor use of ICUs and CCUs.

Hospitals apparently have been successful in getting more testing done prior to admission, thus keeping the cost out of the DRG payment. One physician complains about this trend, claiming that it is poor medicine to rely on several days old tests when treating patients.

Relations between the UR staff and physicians usually is on an informal basis. One UR coordinator put DRG stickers on patient charts for a while showing the DRG and average length of stay, but then discontinued the practice. Another large hospital, however, never gave doctors this information, stressing instead the "medical necessity" of a case. Most hospital administrations get breakdowns of utilization by physician, but explicit procedures for using this information are rare. In one hospital an MD on the peer review utilization committee will occasionally talk to attending physicians about problems. Another UR coordinator comments that because reviewers are all RNs, they work individually with physicians "instead of having a major program to educate the MDs."

5.2.3 Controlling Lengths of Stay

Decreasing the length of stay is being accomplished both at the beginning and at the end of a hospital stay. Surprisingly, there seem to be more complaints about the reduction in hospital days before a procedure is performed. Several doctors remark that they prefer to have a patient admitted one day ahead of surgery, but that this is no longer permitted. Once in the hospital and under the control of utilization review, doctors have little trouble with the speed of discharge, evaluated on medical grounds.

Several, however, complain bitterly that social conditions are a valid criterion for delaying discharge. These are cases of valid (not social) admissions, in which the doctor feels that discharge would cause more medical problems, including a possible readmission. In a few cases, this argument appears to be that proper hygiene or patient education was lacking in certain socioeconomic or racial classes.

Physicians do worry about the results of the trend toward same-day surgery and other procedures now conducted outpatient. One speculates that resulting complications might severely reduce the worth of this decision. As a measure of how much practice patterns have changed, one doctor comments that not long ago, insurers would require admissions for some surgeries now done on an outpatient basis.

5.3 Effects of the PRO

Physicians, medical directors, and UR coordinators all have complaints about the activities of the PRO, with several mentioning a possible problem in coordination of the local office with the headquarters in Birmingham. The state office in Birmingham is the focus of most complaints. Respondents in one major hospital claims that relations with the PRO deteriorated to such an extent that all communications ceased for a time. At another hospital, information from the PRO has reportedly decreased over time. A universal sentiment,

however, is that the PRO has been successful in reducing hospital admissions. One UR coordinator calls this the biggest recent impact of the Medicare program.

Even though much of this pressure is transmitted indirectly to physicians through hospitals, there is abundant evidence that physicians are aware of PRO activities. Several physicians complain about the necessity of calling the PRO prior to an admission, even though approval is not guaranteed.

In addition, there are instances of official sanctions by the PRO for inappropriate admissions. While it appears that no doctor actually is excluded from Medicare practice, a warning has been given to one doctor that on the second sanction he will be excluded from Medicare practice for one year. This doctor feels the admission he was sanctioned for was justified and particularly resents the judgment rendered from another city. He had previously practiced in another state where, he said, local doctors were on the PRO. He felt the lack of local input in Alabama is a serious flaw.

Many doctors also feel that the PRO is unclear and occasionally confusing in what they want. One staff president says the PRO antagonizes MDs by making disputes over diagnoses appear as serious as unnecessary admissions, inappropriate days, etc. Doctors universally attribute the rise in documentation to the PRO, and some argue that the PRO stringency is partly responsible for many readmissions.

6.0 THE POST-HOSPITAL HEALTH CARE INDUSTRY UNDER PPS

The post-hospital industry in Mobile reports typical impacts of PPS on patient care--earlier and sicker discharges, increased complexity of services provided in the home and in nursing homes, and improved discharge planning at the hospital. Nursing home beds and home health care agencies are in adequate supply, presenting no real shortages. As in other sites, some reported placement problems are related to patient status (ability to pay or service needs), not availability of resources. Similarly, there are reports of economic transfer and discontinuation of services due to payment status.

Mobile is distinguished from other sites in two ways. First, the Blue Cross proposed Competitive Medical Plan (CMP) has most providers very angry and anxious about the capitated rates for home care services and durable medical equipment (DME). In addition to the perception that the rates are woefully inadequate, home care providers are concerned about hospital entry into "their" business. Second, every home care provider interviewed mentions the problem of fraud and abuse in the home care and DME business. Blue Cross also raises this issue and its efforts to combat excessive (unnecessary) service provision.

This section includes discussions of discharge planning performed by the hospital, home health care agencies, and nursing homes. Where relevant, CMP is discussed as it affects the different providers. This program is detailed in Section 7.2 on the fiscal intermediary.

6.1 Discharge Planning

Discharge planning has improved significantly in recent years, mostly as a result of PPS but also at the insistence of JCAH in its accrediting of area hospitals. PPS has increased the emphasis placed on discharge planning by expanding its role from providing placement services to performing a vital cost control function. This pressure will increase with the implementation of the Blue Cross CMP program. Under this plan, hospitals are paid a flat $400 per discharge for all home care and DME. One hospital will hire two additional discharge planners to handle the increased workload of these services.

Interviewees report that patients are being picked up earlier during their hospitalization, in some cases at admission or pre-admission testing. Most hospitals use a variety of patient characteristics to flag patients potentially requiring post-hospital care, including: over 70 years old, fractured hip, living alone, stroke, cancer, replacement surgery, psychosis, chronic illnesses, or admission from a nursing home. Discharge planners also acknowledge an increase in the complexity of patients leaving hospitals, as evidenced by the increase in the number of orders for post-hospital services. Furthermore, patients are reportedly discharged without proper education or training due to the short length of stay.

Planners think that there continues to be a lack of physician understanding of the necessity for accurate charts, discharge planning, or of the options for post-hospital services. In some cases, physicians'

ignorance has resulted in increased delegation of responsibility to the nursing and social services staff. Discharge planners have the perception that criteria for nursing home admissions have gotten stricter and therefore fewer such placements are being made.

Discharge planners see their role as presenting choices to patients, assisting decision making, contacting providers, and expediting service arrangements and welfare applications. Some hospitals receive informal assistance from home health agencies, which in turn are soliciting business. Some hospitals are careful to rotate paying patients to different agencies, contrary to agency perceptions about patient placement according to pay status.

6.2 Home Health Care

The home health care (HHC) industry in Mobile includes both non-profit and proprietary agencies, some of which are owned by national chains. Several agencies are also involved in the durable medical equipment (DME) business. None of the providers contract with hospitals, although a few would like to develop "shared services" with the institutions. Contracting is viewed as strictly illegal, violating anti-trust laws. There is a Certificate of Need moratorium limiting the number of agencies. The theory behind the moratorium is to control total expenditures by limiting the number of providers. In contrast, however, it may have kept prices artificially high.

There appears to be a hierarchy of agencies in Mobile, ranging from agencies servicing only patients with clear benefits to those servicing any patient, regardless of eligibility for third party payment. Some agencies openly acknowledge transferring patients to other social service agencies or discontinuing services to patients whose benefits have expired or who no longer meet the skill levels reimbursed by the fiscal intermediary.

These same (for-profit) agencies also complain about the cost caps limiting charges per visit. In contrast, a non-profit agency administrator is very critical of the high prices charged by much of the industry, stating that any agency ought to be able to provide a visit for under $40-45, and that the providers that do not are "motivated by greed." It is not clear if this agency, which has just lowered its charges from $34 to $28, has a less complex casemix.

The multiplicity of fiscal intermediaries (at least three handle HHC claims) also encourages some transfers because a second agency with a different (more lenient) FI could attempt to get coverage for a patient who had exhausted coverage at a previous, more restrictive FI. If denied at the second agency, the services are counted as free care and often the patient would be transferred to the Public Health Service or Visiting Nurse Association, both seen as providers of last resort.

Most providers think that patients are leaving the hospital earlier and sicker, in some cases prematurely. Many interviewees mention that patients are not receiving the in-hospital teaching that previously had been provided during the latter part of a hospital stay. One agency that treats many indigent patients relates their volume increases to the

general growth in uncompensated care, not simply the implementation of PPS. Interestingly, not all providers find that the severity of the patients has increased, suggesting that the very sick patients may be directed to particular agencies and not others. Most agencies however, do mention that PPS has forced them to provide more high tech services (including IV therapy, ventilator monitoring, trach care, and rehabilitation of stroke and cardiac patients) in the home setting. In turn, this demand requires more in-service training of staff, including instruction on IV therapy, chemotherapy, and respirators. Generally, there has been a shift in the hiring practices of agencies, with increasing demand for experienced nurses.

The fact that three FIs handle HHC claims is uniformly mentioned by providers as resulting in discrepancies among agencies as to what services are approved. Regardless of the FI, many providers think that HCFA communicates its policies to the FI, which in turn withholds information from the providers. Poor communication is acknowledged to exist by Blue Cross respresentatives. Agencies also state that they have learned to be very adaptive in their documentation to get around what they perceive to be constantly changing requirements. Some agencies have hired consultants to train them in coding techniques to circumvent restrictions on coverage. Agencies like the idea of regional FIs, hoping this change will standardize approvals and payments.

HHC administrators are very nervous and angry about the Competitive Medical Plan (CMP) proposed by Blue Cross for Medicare beneficiaries. Due to a state moratorium on new agencies, it is unclear if hospitals can establish new home health agencies. As of December 1986, no hospital had contracted with an agency because no agency wanted to commit itself to a fixed fee contract. From the hospitals' perspective, several facilities prefer to set up their own home care programs. Until this issue is resolved, agencies remain uncertain about the impact the program will have on their operations. In addition, a variety of other questions remain unanswered, such as: does the CMP have to use Medicare certified HHA? Who is responsible for monitoring the quality of home care? And, who will approve HHC claims?

Finally, many agencies mention the problem of fraud and abuse among the home care agencies. Apparently, this has been a serious problem that is being corrected. Blue Cross has an active "program integrity" department to investigate HHC and DME providers. For example, currently pending are ten cases of oxygen provision in the home without medical necessity. The CMP is also seen as combatting this problem because it will force hospitals to be prudent purchasers of services. One home care provider thinks that the only way to get rid of the fraud and abuse in the industry is to eliminate the cost caps (which are too generous in this interviewee's opinion) and force agencies to bid for contracts. This would have the added benefit of controlling costs.

6.3 Nursing Homes

Nursing home administrators in Mobile have fairly typical (compared to other sites) comments about the impact of PPS on their operations.

They have noticed an increase in the severity of patients discharged from the hospital, due not only to earlier and sicker discharges, but also because of an informal triage system that has evolved. Less sick patients are now admitted to ICFs or receive home care rather than entering SNFs. Both of these trends result in a sicker patient population in the SNFs. Previously, a home would have avoided admitting patients with serious decubitus ulcers or requiring IV therapy, tracheotomy care, and tube feeding. However, these patients are now frequently found in nursing homes due to the increased severity of discharges. One home has increased its Medicare-certified unit from 16 to 30 beds to accommodate the increase in SNF level patients and has a "subacute unit" to care for its sickest patients. Both of these activities are seen as results of PPS. This same home reportedly has had about one case per month in which the patient died within 24 hours of discharge from the hospital. The administrator feels "hospitals do not like to keep patients who are going to die anyway."

In addition to a triage system allocating patients based on acuity, a hierarchy based on payer mix is also suggested by the administrators. This hierarchy places homes with high turnover at the bottom, because from an administrator's perspective this is the least desirable, and places homes with steady patient populations (private pay and high occupancy) at the top. Administrators of homes with relatively high Medicare payer mix complain of the high patient turnover because Medicare patients often stay until benefits are exhausted before going home, or, in the case of a patient with no financial resources (a Medicaid spend-down patient), being transferred to another nursing home that accepts Medicaid patients.

Mobile appears unusual among the study sites in its multiplicity of fiscal intermediaries processing claims. This variety leads to lack of uniformity in intermediaries' interpretation of definitions of covered services. Every provider mentions the inequities this creates, with some homes being able to get services approved while other homes have much more difficulty. Discharge planners at hospitals are aware of these discrepancies and place patients in homes where approval is likely. Regardless of the intermediary, all providers think that the definitions of care have gotten more restrictive over time. Because some homes have low Medicare volume, one denial can jeopardize their waiver of liability. Many providers say they do not know what definitions are being used to approve cases and that the intermediary is not accessible for answering questions about particular claims. Conversely, at another home with a different FI, prior approvals can be obtained for prospective patients.

Discharge planning in the hospitals appears to have improved somewhat, but continues to need improvement. Homes still get last minute requests for placement and overly optimistic assessments of patient needs. While the number of planners has increased, many are inexperienced and lack knowledge about funding sources and eligibility requirements.

Nursing home administrators think PPS has had some positive effects on their operations. Tighter payments and definitions have made homes

more efficiently managed. Increased acuity has forced homes to increase the skill levels of their staff, which increases their costs but encourages them to provide a wider range of services. However, homes continue to complain about the inadequacy of the rates, and the lack of coverage for services to chronically ill patients. In the future, some providers will move into the high tech business by providing sub-acute care to hospitals' outlier patients.

7.0 PPS PROGRAM OPERATIONS

7.1 Peer Review Organization

7.1.1 Administration

The Alabama Quality Assurance Foundation, Inc. (AQAF) is the Peer Review Organization for Alabama. It had the PRO contract during the first two years of review and, although it did not win automatic renewal for a second contract, it won the business through competitive bidding. Preadmission reviews for hospitals were dropped in the second contract. HCFA claimed it created a conflict of interest for the PRO. In addition to reviewing acute care utilization, the PRO has a contract with 34 nursing homes to process the paperwork for Medicaid and Medicare beneficiaries, and to advise them about which days and services will be covered.

The financial condition of the PRO is such that the administration frequently requires additional working capital to keep operational. Despite HCFA's attempts to focus review and therefore limit PRO expenditures, the PRO thinks that focused review and generic screens are just as costly. Since July, the PRO has laid off 20 people and it has not given salary increases in two years. Six nurse reviewers have left and no replacements are being sought.

7.1.2 Super-PRO Ratings

AQAF performs no additional reviews above the minimally mandated requirements. It has had no real difficulty in its Super PRO agreement rates except for the procedures objectives, it thinks it outperforms its neighboring states. The Super-PRO disagreement rates are shown below:

	Cycle I	Cycle II	Cycle III
DRG Validation	11.0%	12.3%	10.6%
Non-MD Referral	16.4	10.1	15.2
Admission Disagreement	6.5	14.0	9.8
Process Disagreement	12.1	4.1	8.0
Quality of Care	0.8	0.3	2.4

Overall, AQAF staff think their performance is average for the nation. Comparison with two other states, shown below, reflect this. Alabama is high on non-physician referrals but in the middle of the group for most other measures.

	Super PRO Disagreement Rates		
	Alabama	Kansas	Mississippi
DRG Validation	10.6%	10.7%	17.0%
Non-Physician Referral	15.2	10.0	13.9
Admission Review	9.8	9.2	12.6
Process Disagreements	8.0	5.1	5.7
Overall	17.0	14.3	18.3
Quality of Care	2.4	1.3	3.9

AQAF has low denial rates, with the admission reviews presenting the most problems, particularly at small rural hospitals. Now that retrospective reviews are done for most cases, denials have increased. In general, the respondents think HCFA is overly impressed with retrospective recoupments of payment and underestimates the importance of preventing admissions.

7.1.3 Quality Assurance and Medical Review

AQAF has 55 on-site reviewers who visit hospitals on a bimonthly schedule. Severity of illness criteria, necessity of admission, DRG validation, and discharge indicators (to suggest premature discharges) are reviewed by nurses. Questionable cases are sent to physician reviewers, who issue all denials and discuss problems with the attending physicians. Reconsiderations are heard by a utilization committee which makes final determinations about medical appropriateness. Any case may be appealed by the patient to an administrative law judge. These cases are often overturned because the medical charts are not often provided to document medical necessity.

In total, about 10 percent of inpatient stays are reviewed. The five required procedures (pacemakers, CABG, cholecystectomy, carpal tunnel, and gastrostomy) comprise about 5 percent of its cases (versus the national 2.5 percent) requiring more review resources than in other states. Of specific concern in Alabama are: unnecessary admissions associated with COPD, heart failure, gastroenteritis, back pain, radiotherapy, and psychosis. The PRO has noticed shorter lengths of stay with discharges occurring within the profitable span for each DRG. There has been some transfer of expensive cases after minimal levels of care and some hospitals have high readmission rates. Larger hospitals appear to have high rates of premature discharges. Alabama has four "problem" providers (all of the hospitals are about 100 beds). In addition, there has been some inappropriate discharging to SNF units which are in short supply in the state as a whole. Hospitals are just catching onto the 23-hour admission and have begun billing for this service through the outpatient department.

Internal validity of nurse reviewers is checked every three months for percent denied and percent referred to physicians. Reviewers are salaried due to fears that the quality of reviews would deteriorate if reviewers were paid on a per review basis. Reviewers with below standard performance are given one quarter to improve.

The PRO appears unusually open in its communications with hospitals and chiefs of staff. In its announcement of the second contract review criteria, the PRO reportedly sent out a detailed description of the differences between the review criteria of the two contracts, outlined specifically prohibited actions and the review criteria, and provided exact parameters of all generic quality and preadmission/pre-procedure screens. Its willingness to be explicit about (and therefore held accountable to) its interpretations contrasts to PROs visited in other sites. However, there is disagreement over this as Mobile providers often mention increased uncertainty surrounding PRO approvals since the summer of 1986.

7.1.4 Denials and Sanctions

The types of cases generating the most denials include admission review (particularly at small rural hospitals), premature discharge and readmission to hospitals, and specific problematic DRGs outlined previously. Alabama appears relatively lenient in its denial and sanction activity, with three cases during a quarter allowed for non-life-threatening cases (two cases for prohibited actions) before intensified review is initiated for a second quarter. If problems persist, the hospital is notified and a second letter is sent to the physician. Up to this point in the process, a hospital only knows that the physician is on intensified review. In potentially life-threatening situations, the physician is immediately put on intensified review.

Among site providers, one had been sanctioned and a second was reported to be gaming the system by allowing unnecessary admissions and procedures and inappropriately discharging patients to a rehabilitation facility. This second provider pleaded ignorance when confronted with this information by the PRO.

7.2 Fiscal Intermediary

Blue Cross (BC) of Alabama is the fiscal intermediary for all hospitals and about half of nursing homes and home health agencies. The remainder of the post-hospital industry files its claims through Aetna (in Florida) and Mutual of Omaha. This variety of fiscal intermediaries has led to the perception that there is significant variation in services approved for payment. Aetna of Florida will become the regional home health claims processor. At least one respondent does not think this contract was won through competitive bidding.

7.2.1 Claims Processing

About 66 percent of the inpatient claims arrive at BC electronically. All claims undergo edit checks for completeness and medical logic. Incomplete claims are sent back to the provider, not completed in-house after phoning the provider, as is done in some other states. Almost 95 percent of claims are paid within 27 days, with the majority paid 10-12 days after the bill is submitted. A PRO tape is generated daily.

All home health care and nursing home claims arrive at BC as hard copy. Edit checks are performed for missing or incorrect data and are entered into the system daily. Numerous errors in this data cause delays in getting these bills paid promptly. Home health claims average 23 days, while nursing home services take 37 days, compared to the overall average of 14 days.

7.2.2 Utilization and Medical Review

All medical reviews are performed by RNs using informal guidelines developed by the nursing staff and physician advisors. Any questionable

claims are reviewed by the physician consultant. Reconsiderations of denials (requested by the agency) are sent to the regional intermediary in Columbus, Georgia, for review. Overall, the FI reviews about 75 percent of all home care claims and all SNF claims.

In general, the FI reports increased intensity of services provided in the home but that the care rendered in the home setting has not been inappropriate. More high tech care has been delivered in the home setting, particularly the treatment of severe ducubitus ulcers and tube feeding.

The most common denials are for technical reasons: clerical errors, missing fields, and missing documentation. Home visits often do not parallel physician treatment plans, thereby triggering denial. Providers with low Medicare volume reportedly never seem to understand the scope of services covered, which also results in denials. At some facilities, the volume is so low that one claim can trigger loss of a waiver of liability. The FI would like to notify providers that they are close to being removed, but feels it is too much work. Denial rates average 0.11 percent for home care visits, and 7.9 percent for SNFs, over all providers.

The FI respondents state they have no confusion over the definitions of home care services given in the Federal Register. They use the following definitions:

homebound: patient has an incapacitating condition that prevents him/her from getting out of the house without physical assistance. Frequency and duration of visits away from the house are examined, without strict attention paid to the medical necessity of leaving.

daily care: care delivered daily for two to three weeks. Level of care is not carefully screened for skill level or medical necessity. Recertifications are checked more carefully but initial order has no limit on number of visits that can be provided.

intermittent: care delivered 2-3 times per week, but can be daily for a short term. Change in patient status central to eligibility under this definition.

skilled care: services provided by a RN, LPN or other professional.

Compared with other FIs these definitions appear very lenient, and may perhaps be related to the low denial rate mentioned above.

The consistency of reviewers is checked daily through a second review of three claims a day. Productivity of reviewers is monitored weekly and compared to internally developed performance standards.

7.2.3 Relations with HCFA

This FI has good relations with the regional office, with which it communicates on a regular (if not daily) basis. The budget cuts have been significant and, coupled with increasing responsibility, have eliminated whatever flexibility the FI once had. Staff layoffs absorbed much of the financial squeeze three years ago (when its payment per claim dropped from $2.37 to $1.69) and the FI has been reluctant to rehire since then even though its revenues have subsequently increased. For example, instead of hiring auditors it chose to subcontract this work out, thereby keeping its fixed costs to a minimum. In addition, as in other plans, BC of Alabama has subsidized the Medicare work with its private business.

The FI has not had stellar CPEP scores for a variety of reasons. BC has consistently scored below average on correspondence with beneficiaries and providers. Its correspondence reportedly has been found to be inaccurate, incomplete, not responsive to provider questions, and slow. Another problem in its CPEP scoring has been the failure to comply with "work on hand" requirements. Its poor scoring is attributed to "petty mistakes."

BC of Alabama has 70 of its 121 providers on PIP. Its elimination should not be a problem to most hospitals because BC cuts checks weekly. However, it will force hospitals to file claims before payments will be made. Smaller hospitals will reportedly experience high variations in revenue streams, making their operations more costly in terms of working capital.

7.2.4 Competitive Medical Plan

Approval for the first statewide Competitive Medical Plan (CMP) was expected soon after the site visit. Under the plan, hospitals are paid a fixed $400 per discharge to cover post hospital services for the first 60 days after discharge for some 159 DRGs. Services starting on day 61 will be selected and arranged for by BC. If a patient dies, is transferred, or readmitted within 60 days for the same condition, no per discharge payment will be paid for this admission or readmission. On the inpatient side, hospitals will be paid the lesser of the DRG amount or the hospital's inpatient per diem times the length of stay (the BC amount). Outlier payments are fixed prospectively at 5 percent of the aggregate DRG amounts. If a hospital's DRG amount is greater than the Blue Cross amount, then one half of the difference between the DRG amount and the BC amount will be added to the BC amount. Outpatient services are paid at 90 percent of charges up to a ceiling of 116 percent of costs.

Though creating quite a controversy among providers, Blue Cross sees this effort as a logical extension of its two year old PPO, making all providers more competitive. In addition, it hopes that the leverage Blue Cross can place on hospitals will reduce abuse among the durable medical equipment business and home care providers. In contrast,

hospitals feel forced to participate in a program that may not cover their costs and leaves them financially at risk for services that at present they do not directly control.

The plan ignores the existing certificate of need moratorium on new home health agencies, presuming that hospitals can start their own agencies. Existing agencies are afraid that hospital-based programs will be allowed and will take away their business. Providers are reluctant to sign fixed fee contracts with hospitals and yet Blue Cross refuses to contract directly with these providers, preferring to have the hospitals assume the risk for this care. At the time of the site visit, state officials had yet to rule on whether or not hospitals will need a CON and, if so, the status of the moratorium.

A similar plan in Maryland was not approved by HCFA in the summer of 1986. One important difference was that the Maryland program was mandatory for Medicare beneficiaries, whereas the Alabama plan is offered as an alternative to the Medicare wrap-around coverage, C Plus. Critics of the plan have contended that Blue Cross is trying to limit its financial losses ($24 million) from the C Plus plan and eventually will eliminate it as an option.

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